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Faculty practice

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FACULTY PRACTICE

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To Abdo and

my Parents

who graciously

supported me

with their

love and encouragement

ABSTRACT

FACULTY PRACTICE

by Samar Katrib Hage

The purpose of this descriptive survey was to address problems arising from faculty practice. Research questions identified organizational arrangements, perceptions of productivity, satisfaction, and facilitating and inhibiting factors to faculty practice. Role theory provided the conceptual framework. The design was descriptive using a questionnaire with a sample population consisting of nursing faculty from National League For Nursing accredited baccalaureate programs in California. Data were analyzed using count, percentages, means, and ranges.

The majority of faculty were practicing in hospital in-patient settings with clinical practice not arranged through the school. Enrichment of teaching by gaining knowledge through experience was the most important reason to practice. The least important reason was facilitating curriculum change. The leading facilitating factor to faculty practice was scheduling flexibility. The leading inhibiting factor was workload. Recommendations include arriving at a consensus regarding the definition of faculty practice and providing implementation strategies for facilitating the accomplishment of faculty practice goals.

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Chapter 1

INTRODUCTION

This study focuses on the issue of faculty practice, the clinical practice of nursing faculty. The topic has received increased attention in the last few years. However, several critical questions continue unanswered. For example, should teaching faculty in nursing education be required to concurrently maintain, update, and enhance their clinical competency? Will faculty practice promote the improvement of nurse educators' ability to teach due to increased clinical competency? Will faculty practice, in the long run, improve the nursing profession (Kuhn, 1985, p. 10)? From such questions stem the goals of faculty practice.

According to Royle and Crooks (1986), "The goals of faculty practice are to improve the quality of patient care and student learning; to promote professional development of nursing faculty and clinical staff; and to facilitate communication and cooperation between nursing service and education. Faculty practice provides a means of facilitating the development of clinical nursing research and the development and utilization of nursing knowledge" (p. 27). From the second symposium on faculty practice, Fagin (1985) identified the following four principal goals

of faculty practice: (a) clinical excellence, (b) the development of a research and scholarly base, (c) the provision of excellent educational programs, and (d) the empowerment of practicing nurses and the nursing profession.

However, ongoing constraints discourage faculty practice. Such constraints emerge from the faculty responsibilities inherent within academic institutions. These competing responsibilities generally consist of teaching, research, publishing, institutional service, public service, and professional development. The specific requirements of any of these activities depend on the academic institution. Nurse educators spend numerous hours in clinical supervision. They are often expected to acquire a doctorate when it may only be feasible to pursue these goals in conjunction with their faculty position. In addition to these expectations, the issue of faculty practice as a means of enhancing teaching skills and clinical expertise poses a substantial responsibility. Therefore, nursing faculty involved in a faculty practice must manipulate their academic responsibilities and workload in order to fulfill these requirements.

Much of the literature dealing with faculty practice focuses on the organizational structures that are being developed in order to bring the concept of faculty practice to life. A variety of arrangements are being tried;

however, there is always an actual or potential role strain on nursing faculty (McClure, 1987). Furthermore, the profession has no clear definition of the term faculty practice. Therefore, questions exist about what specific activities constitute faculty practice (Chickandonz, 1986).

Various definitions have been used to describe faculty practice. Kuhn (1985) defines it as "periodic and/or continuous involvement of a faculty member in the provision of direct nursing care to patients" (p. 10). Batey (1983) and Smith (1981) have discussed activities which do not meet the requirements of faculty practice. They consider "moonlighting" or part-time nursing positions as noninclusive in the definition of faculty practice. They also consider practice associated with students in clinical settings and occasional care of patients for the purpose of maintaining skills an unacceptable definition of faculty practice. Anderson and Pierson (1983) define faculty practice as "clinical practices involving faculty members with the health care of clients. This practice might be facilitated through a school-run service, dual appointment, joint appointment, faculty moonlighting, or summer clinical employment. This practice should be over and above the expected clinical teaching role" (p. 132). Royle and Crooks (1986) define faculty practice as "the participation

of nurse-faculty in activities related to client care" (p. 27).

This study's purpose was to increase understanding of faculty practice roles and explore perceptions of productivity and satisfaction of those engaged in faculty practice. The broader purpose was to generate data that would identify means to facilitate faculty practice arrangements and the achievement of faculty practice goals.

Problem Statement

Faculty practice lacks a clear definition. Features of organizational structures which foster or impede faculty practice arrangements are not clearly identified. As a result, there is no consensus among nursing faculty that the overall intended goals of faculty practice are being met. In addition, nursing faculty may not agree that faculty practice is realistic in view of their other expectations.

This study seeks to answer the following research questions. The questions originate from a study of faculty practice by Anderson and Pierson (1983) which serves as a model for this research.

Research Questions

1. What are the organizational structural arrangements of those in faculty practice?

a. What types of faculty appointments are there for those in faculty practice?

b. What type of settings do faculty choose for their faculty practice?

2. What are the perceptions of productivity of those in faculty practice?

3. What are the perceptions of satisfaction of those in faculty practice?

4. What are the factors that facilitate and/or inhibit faculty practice as perceived by faculty?

Purpose

The purpose of this study was to explore problems arising from faculty practice with those involved in faculty practice. Another purpose was to (a) describe the prominent organizational arrangements utilized in faculty practice, (b) identify the levels of productivity and satisfaction as perceived by those in faculty practice, and (c) describe the facilitating and inhibiting factors in faculty practice as perceived by those in faculty practice.

Lack of data related to organizational structures influencing faculty practice and nurse educator perceptions regarding faculty practice suggest that there is a need for research on this issue. This study aimed to increase information which may facilitate faculty practice arrangements and the achievement of faculty practice goals.

Definition of Terms

For the purpose of this study the following terms will be used:

1. Faculty practice is the involvement of a faculty member in the provision of direct nursing care to patients. This practice might be facilitated through joint appointment, dual appointment, a school-run service, summer clinical employment, or moonlighting.

2. Nursing faculty are registered nurses employed as nursing faculty members either full- or part-time in formal collegiate nursing institutions.

3. Moonlighting is "clinical practice not contracted by or through the school of nursing" (Anderson & Pierson, 1983, p. 132).

4. Joint appointment is one agreed to by two or more institutions where the appointed faculty member holds a position in each institution and carries out a defined responsibility in each (Davis & Tomney, 1982).

5. Unification model is "the collaborative effort of nurse administrators and educators to advance nursing as a practice discipline in the three areas of practice, teaching, and research" (Chickadonz, 1986, p. 137).

Research Design

This study used a descriptive survey design to explore the research questions on faculty practice. The study

assessed perceptions of nursing faculty related to their productivity, satisfaction, organizational arrangements, and the facilitating and inhibiting factors of their faculty practice.

A letter was sent to the deans/directors of California National League for Nursing (NLN) accredited baccalaureate programs asking them to participate in the study and to identify faculty members who describe themselves as being involved in faculty practice.

The questionnaire was mailed to each person identified by the sampling method. The instrument was a four-page questionnaire with 22 items (Appendix C). The form of questions includes both structured and open-ended categories. All subjects were assured of confidentiality and anonymity and the return of the questionnaire was interpreted as consent to participate in research. A summary of the findings were available on request.

Based on Anderson and Pierson's 1983 study, the analysis of data included descriptive statistics, frequency distribution, means, standard deviation, and percentages. Answers to open-ended questions were categorized using the literature as a guide.

Scope and Limitations

The study was limited by the design, sample, data collection method, and instrument. The use of an

exploratory survey design does not allow the study to suggest any cause and effect relationship. The participation in the survey was limited to faculty members teaching in National League for Nursing accredited baccalaureate programs in the state of California. This group may not be representative of all faculty members involved in faculty practices in other states. In addition, data collection could have been limited by the method in which deans/directors of the programs identified faculty members involved in faculty practice. Further, the instrument has not been subjected to extensive reliability and validity tests. The response rate may also have affected the results; the non-respondents may have contributed substantial findings to this study. Therefore, these limitations suggest that generalizations of this study be made with caution.

Chapter 2

CONCEPTUAL FRAMEWORK AND LITERATURE REVIEW

Conceptual Framework

Role theory provides the conceptual framework for this study. Role theory is a collection of concepts and hypothetical formulations that predict how an individual will perform in a given role, or under what circumstances certain types of behavior can be expected (Hardy & Conway, 1978). Role theory is an interdisciplinary theory that draws its concepts from studies of culture, society, and personality. The broad concepts of the theory are role, the unit of culture; position, the unit of society; and self, the unit of personality (Sarbin, 1954).

The term position is defined as a system of role expectations. Sarbin (1954) goes on to state that "all societies are organized around positions and the persons who occupy these positions perform specialized actions or roles. These roles are linked with the position and not with the person who is temporarily occupying the position" (p. 224). The two major perspectives from which roles and role performance have been studied in behavioral science, and their relevance for health professionals in particular, center on the functionalist and the interactionist approach.

The functionalist views social interaction as environmental forces that act on an individual to produce behavior. Objects and persons are viewed as stimuli which act on an individual. Persons act on the basis of a generally objective reality.

The interactionist views social interaction as a process of self-indication, where an individual accepts, rejects, or transforms the meaning of forces. In this view, an individual gives meaning to objects and makes decisions on the basis of his judgements. In addition, reality is defined by each actor; one defines a situation as he "sees it" and acts on this perception (Conway, 1978, p. 21). The interactionist approach to the study of behavior has clearly taken precedence over functional theory in an attempt to explain human behavior (Conway, 1978, p. 22). In addition, Conway (1978) summarizes that although many hypotheses have been introduced to explain social or role behavior, research is still scarce and caution must be exercised in drawing generalizations.

Specifically, the concept of role strain, which is central to role theory, will be utilized to identify and explain the difficulties associated with faculty practice. Hardy (1978) states, "Role strain is the subjective state of distress experienced by a role occupant when exposed to role stress. Role stress is a social structural condition

in which role obligations are vague, irritating, difficult, conflicting, or impossible to meet" (p. 76). The concept of role strain includes six general categories: role ambiguity, role conflict, role incongruity, role overload, role incompetence, and role overqualification. For this research study, role ambiguity, role overload, and role conflict are particularly relevant to faculty practice issues.

Role Ambiguity

Hardy and Conway (1978) define role ambiguity as lack of clarity in role expectations where the norms are vague, ill-defined, or unclear. Literature on faculty practice supports the fact that role ambiguity does exist. Chickadonz (1986) cites a number of studies done on faculty practice, and in each of the studies "a question is raised about what activities should constitute faculty practice" (p. 143). Varying definitions regarding what activities constitute faculty practice support the idea that there is role ambiguity in faculty practice. Some authors define faculty practice as practice in the context of being faculty. Others exclude moonlighting or a part-time position in their definition of faculty practice. Anderson and Pierson's (1983) study, the model for this research, includes joint appointments, dual appointments, school-run services, summer clinical employment and moonlighting as all

possible definitions of faculty practice in which the faculty member is directly providing nursing care to patients. These inconsistent and unclear definitions related to what constitutes faculty practice may directly lead to role ambiguity. Chickadonz (1986) emphasizes that empirical data in faculty practice require clear definitions.

Role Overload

According to Hardy and Conway (1978), role overload may be defined as difficulty in fulfilling role demands when an individual is confronted with excessive demands. Although the individual is able to perform each role demand competently, he/she is unable to carry out all role obligations in the time available. Role overload is particularly relevant to the faculty practice issue in that it "may occur primarily in higher level positions or in positions that link one or more systems" (Hardy & Conway, 1978, p. 83). Role overload is also more common in emerging roles. Royle and Crooks (1986) state that "role fragmentation and work overload result when faculty attempt to perform each function separately within the different social and bureaucratic structures of the university and the health care delivery system" (p. 27). Anderson and Pierson's exploratory study (1983) identified the perceived workload as the greatest inhibitor of faculty practice.

McPhail (1980) identified workload and schedules as the two factors most often cited by faculty as major deterrents to involvement in direct care.

Role Conflict

According to Hardy and Conway (1978), "role conflict is a condition in which existing role expectations are contradictory or mutually exclusive" (p. 82). The study of role conflict examines the existence of clear but competing role expectations. Examples of conflicting role expectations in relation to faculty practice are evident when one's work exists in two setting, with two supervisors, and two sets of responsibilities. According to Diers (1980), when very few provisions are made by administrators to provide adequate time for faculty to complete individual teaching assignments, committee work, etc. in conjunction with faculty practice, role conflict surfaces. Dickens (1983) concurs by stating that "the maintenance of a nursing practice, in addition to other activities required of a faculty members, puts a heavier load on already overburdened time and energy commitments of the nurse educator" (p. 121).

Review of Literature

The original setting for educating nurses in the 1890's was the hospital. Nurses in training followed an apprentice model, learning from head nurses and other students. After World War II, the government began giving financial support

to nursing education. Baccalaureate programs in colleges and universities began forming in the early 1900's and the associate degree programs grew during the 1950's. By the 1960's most nursing education took place in institutions of higher learning. Separation of service and education was now complete (Kuhn, 1985, p. 10). According to Anderson and Pierson (1983), "it was possible to be a nurse educator with teaching credentials and limited clinical experience" (p. 130). Kuhn (1985) states that this schism promoted a disharmony between nursing service and nursing education, and in addition it brought about a lack of credibility for the nurse educator (p. 10).

One of the first to set the trend for collaboration between service and education was Dorothy Smith in 1956. Since then, the concept of faculty practice has become more prominent, and schools/departments of nursing have begun to be viewed as places were nursing education is both taught and practiced (Royle & Crooks, 1985, p. 29).

The statement of belief states that the major driving forces for involvement in faculty practice have been to guide clinical research, generate theory, strengthen the instructor role, and improve the effectiveness of patient care (Christman, et al., 1979). According to McClure (1987), "practice provides the teacher with the opportunity to learn continually, to gain new insights, and verify

long-held ideas about the delivery of nursing care to patients. This knowledge can then be used to enrich the material presented in the clinical laboratory" (p. 163). McClure (1987) points out that equally important is the relationship between practice and research. Scholars who are not involved in practice will never be in the position to address the arousing questions that must be studied in the hopes of contributing to the improvement of nursing practice.

A variety of nursing models and arrangements have been proposed to bridge nursing service and nursing education. Nursing leaders believe that unification models are a key element to making faculty practice work. In the two operating models existing at Rochester and Rush University, faculty involved in the unification models are responsible to both the school and hospital. They negotiate with the administrators as to the proportion of time they will spend in teaching, research, and service (Ford, 1981). For many schools/departments, single administrations are not feasible; therefore, other models have been used in the attempts of resolving the separation between practice and education. Such models include joint appointment, dual appointment, moonlighting, and school-run projects. The various models have created an entirely new set of problems within the areas of finance, workload, and reward systems (Anderson & Pierson, 1983).

Published research on faculty practice was identified from the literature search. The studies about to be described focus on three areas of research: (a) types of faculty practice, (b) factors affecting faculty practice, and (c) receptivity to a unification model for faculty practice.

Types of Faculty Practice

Types of faculty practice were addressed by Rosswarm's 1981 study. The study sought to reveal the characteristics of a nurse faculty group practice. This was defined as "a faculty group which works as a team to deliver direct care to clients" (p. 237). The study also sought to reveal characteristics of the clients served, and the major problems and benefits experienced. The major problems identified were scheduling problems for both teaching and practice. Another problem was a limitation in reimbursement. The major benefits cited were job independence, satisfaction, and excitement of practice. In addition, maintenance of clinical skills, and serving as a role model for students were notable benefits. Weaknesses of the study centered on lack of clarity in describing faculty practice.

Joint appointment is another type of faculty practice which was addressed by Davis and Tomney (1982). Results from the questionnaires distributed revealed that 10 of

the 16 nursing schools in Canada had jointly appointed positions of two types: those with cost-shared appointments and those with non-cost shared appointments. Acute care hospitals were identified as the most common joint appointments with the school of nursing. Major limitations of this study centered on definition of terms, lack of data about the roles described, and lack of definition about the characteristics of the joint appointments. The author suggested that further studies should be aimed at describing joint appointment as well as other nursing models and practice in the United States.

Factors Affecting Faculty Practice

Factors affecting faculty practice were addressed by two studies, Anderson and Pierson (1983) and Dickens (1983). They address factors which facilitate and factors which inhibit faculty practice. Since this current research is modeled after Anderson and Pierson's 1983 study, the findings will be described in detail.

Anderson and Pierson based their research on role theory and focussed on the importance of the students viewing their instructor as a role model who is both knowledgeable in the area of nursing practice and capable of demonstrating clinical skills. An exploratory survey was used to elicit responses from 127 National League for Nursing accredited baccalaureate programs in the United

States. Faculty who practice were identified through a letter of inquiry to the deans of those schools. Completed questionnaires returned numbered 573 of the 972 faculty who comprised the final sample. Faculty practice was defined as "clinical practice involving a faculty member with the health care of clients. This practice should be over and above the expected clinical teaching role" (p. 132). A more specific term of moonlighting was used to designate "clinical practice not contracted by or through the school of nursing" (p. 132). Results of the study indicated that 18% of the respondents practiced only during vacation breaks and during the summer. With the remaining respondents, over half of the subjects averaged approximately 8 hours or less of practice per week. The median weekly workload was 45.6 hours.

The findings indicated that the most important reason to practice were enriching teaching, maintaining clinical skills, and personal satisfaction. The least important reason to practice was found to be related to research and curriculum. Joint appointments were held by 17% of the sample, and moonlighting was indicated by 48% as a means of accomplishing faculty practice. Fifty-eight percent of the respondents used the hospital as the setting for practice, the most frequently used setting.

Thirty-seven percent of the respondents reported that faculty practice was included in the school's philosophy; however, 58% of the total sample indicated that no time was purposefully allocated for practice. Nineteen percent of the sample indicated that the school had authority and accountability over the setting in which a faculty member should practice. Twenty-six percent of the respondents indicated that there were criteria present for evaluating the practice component. A reimbursement policy for faculty practice was reported in 10% of the respondents. The greatest facilitator of faculty practice was found to be administrative support; in contrast, the primary inhibitor of faculty practice was the workload.

Salary supplementation was viewed as a facilitator of practice. Respondents indicated that students responded positively to their practice; however, half of the faculty respondents indicated that their nursing colleagues responded negatively. When responses of faculty from unification model schools and those from other models were compared, there was no difference in terms of total hours of weekly workload. However, administrators were seen as facilitators of faculty practice by a higher proportion of those in unification models than other models and as an inhibitor in higher proportion of non-unification models than unification models.

Anderson and Pierson (1983) recommended future research in areas of hospital administrator and service personnel attitudes to faculty practice, comparison of satisfaction levels of faculty to different specific models, factors affecting workload, and impact on clients and students. Limitations of the study centered on lack of development of role theory concept and lack of clarity in terminology.

Dickens' (1983) study examined existing mechanisms of social support for faculty who practiced and recognized their ambivalence to becoming involved in practice. The survey was conducted among nursing administrators in baccalaureate and master's degree programs in the southeastern region of the United States. Seventy-four of the 113 administrators responded to the survey. Administrators reported that in the 1981-1982 academic year, 32% of their full-time and 42% of their part-time faculty were involved in faculty practice. The types of faculty practice were varied including joint appointment, group practice, and private practice. Fifty percent of full-time faculty were involved in practices identified as summer, weekend, and recess break practice in various health agencies. Forty-six percent of part-time faculty were involved in joint appointments. Conclusions of the study revealed that limited evidence of appraisal support for faculty who practice existed, although some evidence of emotional support was present.

Faculty Receptivity to Unification Models

The last study to be discussed addresses the question of receptivity to a unification model for practice among nursing faculty in the United States. Yarcheski and Mahon (1985) conducted the study by examining the degree of receptivity among groups of deans, tenured faculty, and nontenured faculty.

The sampling procedure was systematic and random in nature. It identified 298 educators from baccalaureate nursing programs accredited by the National League for Nursing for 1982-1983. Seventy-five percent returned usable responses. They included 72 deans, 64 tenured, and 86 nontenured faculty. Description of the unification model developed included the purposes, organizational arrangements, dean and faculty responsibilities, and arrangements for practice activities and workloads. The status-risk theory of receptivity to change was the framework for this study. It proposed to see the relationship between a status or position held and the degree to which an innovation, e.g., unification model, threatens or benefits the person's status.

Results of the study did not indicate significant differences among the three groups. However, there were nonsignificant differences regarding receptivity to the model with nontenured faculty having the highest receptivity

to the model followed by the deans and then tenured faculty. In addition, findings revealed that receptivity to unification among the three groups related directly to the risk or benefit perceived. That is, higher levels of receptivity were significantly correlated with lower levels of risk and higher levels of benefit. The major limitation of the study was inadequate theory base and lack of support by the literature. In addition, the description of risks and benefits perceived by the three groups were limited as well.

The studies reviewed thus far have been mostly descriptive in nature. They only begin to address the questions related to faculty practice by indicating that "faculty practice is occurring and that there are varying degrees of receptivity to introducing the unification model" (Chickadonz, 1986, p. 145). Existing literature shows a lack of clarity as to what activities should constitute faculty practice. In addition, most studies lack theoretical conceptualization for guiding research (Chickadonz, 1986).

Chapter 3

METHODOLOGY

This chapter describes the research design, sample setting, data collection, instrument, measurements, and data analysis used in this study. The goal is to describe factors which may facilitate faculty practice arrangements and to explore perceptions of productivity and satisfaction of those engaged in faculty practice.

Research Design

The design for this study was a descriptive survey using a questionnaire. This was an appropriate manner of gathering data due to the limited published research on the subject. The advantages of this methodology are that it is less time consuming and less costly than a personal interview. Respondents can be granted anonymity and the interview bias is not present. In addition, a wide geographic area can be surveyed easily (LoBiondo-Wood & Haber, 1986). The disadvantages are that a mailed questionnaire has the possibility of a low response rate, which may produce a biased sample.

Sample and Setting

The sample population for this study consisted of nursing faculty from National League for Nursing (NLN) accredited baccalaureate programs in the state of California

who described themselves as having faculty practice involvement. A list of NLN accredited baccalaureate programs in the United States was obtained from The List of State Approved Schools of Nursing RN (1988) guide published by the division of research of the NLN. Twenty-seven nursing program were identified in California.

A total of 25 programs participated in this study (93%). Two programs did not participate due to (a) no faculty involvement in faculty practice or (b) the university was not willing to participate in the study. A total of 416 questionnaires were sent and 206 returned; 170 (41%) were actually involved in faculty practice. The remaining 36 (8%) were not actively participating in faculty practice; therefore, they were excluded from the study.

Data Collection

Data were collected jointly with another San Jose State University graduate student who used the same instrument, the same sample population, and similar data. Therefore, the instrument was used to collect data for both studies to avoid duplication and minimize inconvenience to those faculty completing the questionnaire.

Deans/directors in each of the 27 NLN programs were contacted by phone to identify faculty who were in faculty practice. The study was described briefly. A list of names of faculty who describe themselves as involved in faculty

practice was requested. The majority of deans/directors were unwilling to disclose such names for two main reason: (a) permission to disclose names was against department policy, or (b) deans/directors were uncertain as to which instructors had faculty practice involvement. Given these constraints, the number of questionnaires mailed to the schools was solely based on the deans/directors estimated numbers of faculty in faculty practice.

The suggested number of questionnaires (as perceived by deans/directors) was mailed as a packet to each program dean/director contacted. Included in this packet was an introductory letter to the deans/director (Appendix A), a cover letter to each nursing faculty member involved in faculty practice (Appendix B), with a questionnaire and self-addresed enveloped attached (Appendix C). The introductory letter reaffirmed the previous phone conversation held with the dean/director. In addition, it described the process of packet distribution to nursing faculty involved in faculty practice. The cover letter to each faculty member described the purpose of the study and provided a definition of faculty practice. In addition, instructions for participation and consent were included. Return of the questionnaire indicated consent to participate in the study.

Instrument

The instrument was a four-page questionnaire with 22 items (Appendix C). The form of the questions included scaled response, Likert-type items and open-ended items. Permission to use the questionnaire was granted by its authors, Anderson & Pierson (1983). The instrument was modified to fit the purpose and research questions of the study. The intent of the questionnaire was to: (a) gather demographic data, (b) describe faculty practice arrangements, (c) obtain information regarding a nursing faculty's perception of productivity and satisfaction in regard to faculty practice, and (d) identify factors which facilitate or inhibit faculty practice. Content validity was originally established by a panel of nurses who had reviewed research studies and other literature on faculty practice (Anderson & Pierson, 1983). After modifying the questionnaire for this study, five nursing faculty involved in faculty practice were asked to assess the content validity of the questionnaire.

Measurement

Demographic data were obtained from items 1 through 10. The description of faculty practice arrangements was assessed with item 11 which asked for type of appointment and role responsibilities of each faculty member. Data on how faculty practice is accomplished within the time frame of

the total faculty workload were assessed in items 12 and 13. The type of setting faculty choose for their faculty practice was assessed in item 14. Facilitating and/or inhibiting factors as perceived by those in faculty practice were addressed in items 15, 17, 18, 21, and 22. Perceptions of relevance/productivity for those in faculty practice were assessed in items 16 and 20. Perceptions of satisfaction for those in faculty practice were addressed in item 19. A commentary paragraph was available at the end of the questionnaire to allow any additional remarks regarding the survey.

Data Analysis

The data gathered from the questionnaire were analyzed using descriptive statistics. To provide a profile of the respondents, demographic data were analyzed using frequencies, percentages, means, and ranges. Quantitative responses were analyzed using frequencies and percentages. Open-ended responses were listed and grouped into categories based on a review of the literature. Categories were analyzed using frequencies and percentages.

Chapter 4

ANALYSIS AND INTERPRETATION OF DATA

Analysis

This study aimed to describe faculty practice arrangements for those in faculty practice. In addition it describes the facilitating and inhibiting factors in faculty practice and the perceived level of productivity and satisfaction of those in faculty practice.

Characteristics of the Sample

Tables 1 and 2 describe the demographic variables of the sample: sex, age, education, and experience as a nurse, a nursing educator, and in a clinical specialty area. In addition, they describe department of nursing affiliation with a teaching hospital and memberships in a professional nursing organization (items 1-10).

Table 1 shows that the majority of respondents were female (95%), aged 30-39 (35.1%) or 40-49 (39.1%). Most respondents (61.6%) had completed a Master's Degree in nursing. Medical/surgical and community health were the most commonly checked specialty areas, (25.5%) each. Most of the respondents (54.5%) were not affiliated with a teaching hospital. Ninety-three percent of the respondents were members of a professional nursing organization. Table 2 shows that the average number of years taught in a a school of nursing was ten years.

Table 1

Demographic Data (n=170)

	n	%		n	%
Sex			**Age**		
Male	8	4.8	20-29	5	3.4
Female	159	95.2	30-39	53	35.3
Missing	3		40-49	59	39.2
Total	170	100.0	50-59	30	19.9
			Over 60	3	2.0
			Missing	20	
			Total	170	99.8
Affiliation With A Teaching Hospital					
Yes	76	45.5			
No	91	54.4			
Missing	3				
Total	170	100.0			
Highest Degree			**Membership in A Professional Nursing Organization**		
Baccalaureate/Nursing	2	1.3	Yes	156	93.4
Baccalaureate/Other	0	0.0	No	11	6.6
Nursing Master's	98	61.6	Missing	3	
Non Nursing Masters	1	0.6	Total	170	100.0
Nursing Doctorate	21	13.2			
Non Nursing Doctorate	37	23.3			
Missing	11				
Total	170	100.0			
Specialty Area Experience					
Medical-Surgical	37	25.5			
Community Health	37	25.5			
Gerontology	16	11.0			
Pediatrics	8	5.5			
Parent/Child	11	7.6			
Mental Health	15	10.3			
Other	21	14.5			
Missing	25				
Total	170	99.9			

Note. Percentage totals may not add to 100% due to rounding.

Table 2

Sample Work Experience

	M	Range
Number of Years Worked as A Registered Nurse (n = 166)	15	1 - 40
Number of Years Taught in A School of Nursing (n = 167)	10	1 - 35

Note. Number of responses varies due to unanswered items. Usable questionnaires = 170.

Faculty Practice Arrangements

Table 3 describes faculty practice arrangements for those in faulty practice (item 11). Data revealed that 79.5% of reported faculty practice was clinical practice not arranged through the university or school. Only 9.0% of faculty reported participating in joint appointment arrangements. Also included in item 11 was a category entitled Other. Responses originally placed in that category were moved to another category described as clinical practice not arranged through the university or school. This was done in order to place the responses in the most appropriate corresponding category.

Table 4 addresses faculty practice settings (item 14). Data revealed that 49.6% of the respondents performed their faculty practice in hospital in-patient settings.

Table 5 describes faculty accountability to the department of nursing for their involvement in faculty practice. Eighty-one percent of the respondents noted that they were not accountable to their department of nursing for their involvement in faculty practice (item 15).

Table 6 reports the presence or absence of established criteria within the department of nursing for evaluating the effectiveness of faculty practice. Eighty-nine percent (89.8%) reported that their department of nursing did not have established criteria for evaluating the effectiveness

Table 3

Description of Faculty Practice Arrangements (n=170)

	n	%
Joint Appointment	14	9.0
School/Department run service	18	11.0
Clinical practice not arranged through the university or school	132	79.5
Missing	6	
Total responses	170	99.5

Note. Percentage total does not add to 100% due to rounding

Table 4

Characteristics of Faculty Practice Settings (n=170)

	n	%
Hospital In-Patient	58	49.6
Community Agency/Clinic	19	16.2
Hospital Clinic/Out-Patient	11	9.4
Private Practice (from home or office)	5	4.3
Private Practice and Partnership From Physician's Office	4	3.4
Consultant	3	2.6
Other	14	12.0
Missing	56	
Total Responses	170	100.3

Note. Percentage totals exceed 100% due to rounding.

Table 5

Faculty Accountability to Department of Nursing For Involvement In Faculty Practice (n=170)

Response	n	%
Yes	31	18.8
No	134	81.2
Missing	5	
Total Responses	170	100.0

Table 6

Criteria For Evaluating The Effectiveness of Faculty Practice (n=170)

	n	%
Yes	16	10.2
No	141	89.8
Missing	13	
Total Responses	170	100.0

of the faculty practice component of their teaching position (item 18).

Faculty Practice Relevance/Productivity

Table 7 addresses faculty beliefs regarding the importance of faculty practice to the nurse educator role (item 16). Findings revealed that 60.2% of the respondents believe that faculty practice is very important to the nurse educator role. Very few respondents (0.6%) report that faculty practice is not at all important to the nurse educator role.

Table 8 describes faculty practice's perceived relevance to the nurse educator role (item 20). Perceived reasons of importance for faculty practice were sought by ranking relevance/productivity from 1 to 10 (1=most important reason, 10=least important reason). The mean importance rank was computed by multiplying the number of times each reason was checked with the ranking number (1 to 10) and then summing and dividing by n=128.

Findings revealed that the most important reason for faculty practice's perceived relevance was enrichment of teaching by gaining knowledge through experience. The second and third most important reasons for faculty practice were maintenance of clinical skills and the ability to function as a better role model to students. The least important reasons for faculty practice were found to be

Table 7

Importance of Faculty Practice To The Nurse Educator Role (n=166)

1 Very Important		2		3		4		5 Not At All Important	
n	%	n	%	n	%	n	%	n	%
100	60.2	41	24.7	20	12.1	4	2.4	1	0.6

Table 8

Perceived Importance of Faculty Practice To The Nurse Educator Role (n=128)

Reason	Mean Importance Rank
Faculty Practice:	
Enriches teaching by gaining knowledge through experience	2.3
Allows one to maintain his/her own clinical skills	3.1
Allows one to function as a better role model to students	3.4
Allows one to gain credibility with staff and influence staff practice	5.2
Enhances personal satisfaction	5.5
Improves quality of nursing care	6.2
Generates hypotheses for research	6.8
Establishes harmonious relationships between nursing service and nursing education	7.1
Enhances autonomy in practice	7.3
Facilities curriculum change	7.6

Note. 1= most important; 10 = least important

enhancement of autonomy in practice and facilitation of curriculum change.

Faculty Practice and Levels of Satisfaction

Table 9 describes satisfaction levels of respondents regarding their current involvement in faculty practice (item 19). Data show that 53.9% of the respondents are fairly satisfied with their current faculty practice involvement. Twenty-six percent are very satisfied and 1.8% are extremely dissatisfied with their faculty practice involvement.

Facilitating Factors to Faculty Practice

Table 10 describes the factors which facilitate faculty practice (item 21). The participants' responses to the open-ended questions were placed in categories of facilitating factors as identified from the literature review.

Data revealed that one leading factor in facilitating faculty practice, as perceived by those in faculty practice, is scheduling flexibility and release time (32.3%). An equally facilitating factor (32.3%) is support and encouragement from peers and administration. Other noted facilitating factors included an arena for maintenance of clinical skills, salary supplement, the availability of a variety of modes to accomplish faculty practice, and one's personal desire, commitment, and motivation to practice.

Table 9

Satisfaction Levels and Faculty Practice (n=165)

1 Very Satisfied		2 Fairly Satisfied		3 No Opinion		4 Fairly Dissatisfied		5 Very Dissatisfied	
n	%	n	%	n	%	n	%	n	%
43	26.1	89	53.9	10	6.1	20	12.1	3	1.8

Table 10

Factors That Nursing Faculty Believe Facilitate Faculty Practice (n=140)

Factors	Responses	% of Identified Factors
Scheduling flexibility/release time	53	32.3
Support/encouragement from peers and administration	53	32.3
Provides the arena for maintenance of clinical skills	13	7.9
Income/salary supplement	11	6.7
Variety of modes available to accomplish faculty practice	11	6.7
Personal desire/commitment/motivation	11	6.7
Harmonious nursing service/nursing education relationships	6	3.7
Affiliation with hospital/clinic	5	3.1
Access to research subjects	1	0.6
Total responses	164	100.0

Note. Multiple responses permitted.

Harmonious nursing service/education relationships, affiliation with hospital clinics, and access to research subjects were less frequently noted as facilitating factors to faculty practice.

Inhibiting Factors to Faculty Practice

Table 11 describes inhibiting factors to faculty practice (item 22). Categories of inhibiting factors were identified from the literature review. Thereafter, the participants' responses to the open-ended questions were placed in categories of inhibiting factors as identified from the literature review. Fifty-nine percent (59.5%) of responses indicated that the perceived leading inhibiting factors to faculty practice are workload and time constraint. The second leading inhibiting factor to faculty practice is lack of recognition and value by faculty and/or administration (16.5%). Other inhibiting factors reported in the data included faculty practice's lack of recognition towards promotion/tenure and lack of joint appointments and/or organizational arrangements in place. Lack of monetary reward and the expectation to conduct research, publish and complete a doctorate in conjunction with faculty practice were also noted factors which inhibit faculty practice.

Table 11

Factors That Nursing Faculty Believe Inhibit Faculty Practice (n=158)

Factors	Responses	% of Identified Factors
Workload/time constraints	141	59.5
Lack of recognition/value by faculty and/or administration	39	16.5
Lack of contribution for promotion/ tenure	14	5.9
Lack of joint appointment/ organizational arrangements	13	5.5
Lack of monetary reward	11	4.6
Expectation to conduct research, publish and complete a Ph.D.	11	4.6
Lack of written policy	8	3.4
Total responses	237	100.0

Note. Multiple responses permitted.

Interpretation

Faculty Practice Arrangements

The majority of respondents reported that their faculty practice arrangement was clinical practice not arranged through the university or school. Perhaps the reason for such a response was that very few joint appointments exist in which the administration facilitates faculty practice. Further, respondents reported that the majority of faculty practice is occurring in hospital in-patient settings. Perhaps that is because hospital in-patient settings are the most accessible and practical settings to arrange faculty practice.

Faculty Practice Relevance/productivity

Findings revealed that the most important reason for faculty practice is enrichment of teaching by gaining knowledge through experience. Maintenance of clinical skills and the ability to function as a better role model were of major importance as well. Perhaps the reason for such a response was that the prevalent clinical arrangement and setting chosen by the faculty allowed them to achieve such goals.

Facilitating and Inhibiting Factors To Faculty Practice

Respondents reported that the greatest facilitating factor of faculty practice is administrative support while

the greatest inhibiting factor is workload/time constraints. One may assume that with support, encouragement, and allotment of release time through administration, the concept of faculty practice could be more feasible and tangible.

Chapter 5

CONCLUSION AND RECOMMENDATIONS

Findings in this study reveal that the majority of faculty practice is clinical practice not arranged through the university or school, and that practice is mainly taking place in hospital in-patient settings. Most respondents believe that faculty practice is very important to the nurse educator role. Enrichment of teaching by gaining knowledge through experience and maintenance of clinical skills are the two most important reason for faculty practice, according to the respondents. The two least important stated reasons for faculty practice are enhancement of autonomy in practice and facilitation of curriculum change. Most respondents reported being fairly satisfied with their current faculty practice involvement.

The leading facilitating factors to faculty practice were scheduling flexibility and release time. Support and encouragement from peers and administration were equally important factors in facilitating faculty practice. Leading inhibiting factors to faculty practice were workload and time constraints. The second leading inhibiting factor to faculty practice was lack of recognition and value by faculty and/or administration.

Conclusion

Findings from this study closely parallel literature review findings. Since this research has been modeled after Anderson and Pierson's (1983) study, the two studies will be compared.

Results in both studies indicate that clinical practice not arranged through a university or school is the major means of accomplishing faculty practice, and hospitals are the most frequently used settings. The two most important reasons to practice in both studies were enrichment of teaching and maintenance of clinical skills. The least important reasons to practice in both studies were facilitating curriculum change, generating hypotheses, and enhancing autonomy in practice.

The greatest facilitating factor of faculty practice in both studies was administrative support. Dicken's (1983) study also found that support for career development and role transition was very important for faculty members to maintain practice activities. Scheduling flexibility/release time was found to be another leading facilitating factor of faculty practice in this study.

The greatest inhibiting factor to faculty practice in both studies was workload and time constraint. Further, only a small number of the respondents in both studies (19%)

indicated that the school had authority and accountability over the setting for faculty practice.

In both studies, the clinical arrangement of practice had not been arranged through the university or school. This finding would indicate that the school is not acting as a facilitator in providing practice opportunities for faculty.

Unique findings of this study are the respondents' reasons given for faculty practice. While the literature identifies research, theory, and curriculum development as primary reasons for faculty practice (Chickadonz, 1986; Royle & Crooks, 1986), field study findings suggest otherwise. The most important reasons identified were: (a) enriching teaching by gaining knowledge through experience, (b) maintaining clinical skills, and (c) functioning as a a better role model. Curriculum and research development were identified as the least important reasons for faculty practice.

Some respondents commented about having difficulties answering two items on the questionnaire (items 11 and 20). Item 11 asked the respondents to mark the statement that best described their faculty practice arrangement. A number of respondents commented that they were confused about how faculty practice was defined even though it was defined for each respondent in the cover letter. This concern with the

definition of faculty practice parallels literature review findings that there is a lack of clearly defined terms which describe faculty practice (Chickadonz, 1986). The conceptual framework, role theory, also suggests that role strain exists when there is a deficit in clearly defined role expectations (Hardy & Conway, 1978). Therefore, the lack of a definition may well be a source of role strain for faculty practitioners.

Findings in this study suggest that role ambiguity, role conflict, and role overload may well be apparent in present clinical faculty practices. Role ambiguity and role conflict is inherent in today's definition of faculty practice. The lack of clearly defined terms for describing faculty practice has led to minimal direction in planning successful implementation strategies for achieving faculty practice. As a result, nurse educators are seeking clinical arrangements on their own terms with little support and recognition from colleagues and administration. Work loads and time constraints are leading inhibiting factors to faculty practice. These factors create role overload for nursing faculty who are accomplishing their required teaching load in conjunction with faculty practice.

Item 20 was another area of concern and confusion for the respondents. The item asked the respondent to rank from 1 to 10 in order of importance (1=most important and

10=least important) the reason they feel faculty practice is relevant/productive to the nurse educator role. Many respondents commented on how annoying it was to answer a ranking question. Several respondents did not answer the question according to the instructions provided; therefore, several responses to this item had to be excluded from the study. The lack of clarity regarding the goals of faculty practice may have been the reason for such a response, or it could have been due to the way in which the question was stated.

The findings may have been influenced by the practice arrangement of the sample. However, the reported reasons for faculty practice were consistent with the most commonly utilized faculty practice arrangement of moonlighting (defined in this study as clinical practice not arranged through the university or school). For example, maintenance of clinical skills and gaining knowledge through experience were the two most important reasons stated. Most respondents were participating in moonlighting arrangements which were accomplished in hospital in-patient settings, an arena that allows maintenance and refinement of clinical skills.

Perhaps the findings would have been different or even reversed if the most commonly utilized faculty practice arrangement had been one in which nursing education and

nursing service had mutually agreed upon goals and objectives for the faculty practice experience.

The two items of confusion noted on the questionnaire center on the definition and goals of faculty practice. Interestingly enough, they are the two areas that require clarification and refinement as noted by the literature reviewed on faculty practice (Chickadonz, 1986).

The following section contains recommendations for schools/departments of nursing who wish to facilitate faculty practice, as well as recommendations for future research. These recommendations are based on data from this current study.

Recommendations for Facilitating Faculty Practice

This study suggests several means to facilitate faculty practice. First, present definitions of faculty practice are broad and vague. A school/department of nursing needs to arrive at some consensus regarding the definition of faculty practice. This might eliminate confusion regarding the implementation of faculty practice arrangements.

Perhaps the schools/departments of nursing could benefit from one broad definition of faculty practice and several goal-directed, specific sub-definitions that parallel the variety of reasons nurse educators perceive faculty practice is important to the nurse educator role.

These goal-directed definitions would delineate and describe the specific role expectations and activities necessary for achieving each specific goal of faculty practice.

Administrative support has been found to be the greatest means of encouraging faculty practice. Therefore, the school/department of nursing can encourage practice by assisting the faculty in setting up a clinical arrangement for meeting faculty practice goals.

Workload and schedules are two of the leading deterrents to involvement in faculty practice. One can appreciate faculty members' priority given to teaching, committee work, and curriculum development. Therefore, workloads and planning schedules that allow adequate time for faculty practice must be constructed.

Finally, faculty practice is not widely considered towards promotion or tenure. Therefore, if faculty practice is valued and expected of nurse educators, institutional expectation (e.g., criteria for promotion and tenure) should be congruent.

Recommendations For Future Study

The population in this study appears to be a representative sample of those in faculty practice; however, generalizations are limited due to the exclusion of the

remaining states from the study. Therefore, the study should be repeated in another geographical area.

The time of year may have had some influence on the success of questionnaire distribution and data collection. Contacting the deans/directors during winter break and expecting responses from the sample during the first 2 weeks of the spring semester, a busy time for faculty, was difficult. Perhaps choosing a more appropriate time for questionnaire distribution would benefit the study. The data collection process should include securing a list of faculty who identify themselves as being involved in faculty practice. Further, a refined method for distribution of questionnaires by deans/directors should be addressed.

The questionnaire did not request information identifying faculty workload as part-time or full-time. Future research questions need to address this area. The instrument requires rigorous testing for validity and refinement for clarity; items 11 and 20 were particularly confusing.

Finally, findings in this study gave rise to concerns regarding faculty practice arrangements and the perceived importance of faculty practice. Additional studies are needed to investigate the relationship between faculty practice arrangements and the perceived importance of faculty practice to the nurse educator role.

Summary

Practice is an attainable expectation for faculty in a practice-oriented discipline. The development of a practice base is hindered by workload, scheduling constraints, and lack of support and collaboration between nursing education and service. Continuing to ignore these findings may have serious implications for the quality of care provided to clients, for the development of research, for the quality of learning opportunities provided to student, and the efficacy of the educational programs that prepare them for entry into practice. The choice sits with each nurse educator, whether to maintain the status quo or to design and test new faculty practice arrangements that will promote collaboration and faculty involvement in the delivery of nursing care.

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APPENDIX A

Introductory Letter to Deans/Directors

1137 Patterson Lane
Pacific Grove, CA 93950

Several weeks ago we discussed on the telephone our intent to complete a study on faculty practice for completion of a Master's Degree in Nursing at San Jose State University. Toward this end, my colleague and I would appreciate your distribution of the enclosed material to those nurse educators who describe themselves as being involved in faculty practice. We have defined faculty practice as:

> The involvement of a faculty member in the provision of direct nursing care to patients. This practice might be facilitated through joint appointment, dual appointment, a school-run service, summer clinical employment, or moonlighting.

We would greatly appreciate your distribution of this material at your earliest convenience in order to facilitate data analysis. Thank you for your time and consideration.

Sincerely,

Samar K. Hage

APPENDIX B

Cover Letter

S. Hage
1137 Patterson Lane
Pacific Grove, California 93950

P. Nervino
26030 Ned Lane
Carmel Valley, California 93924

January 28, 1989

Dear Nurse Educator,

As graduate students in nursing at San Jose State University we are conducting a study on the issue of faculty practice as an integral component of our graduate work. The enclosed questionnaire is being distributed to nurse educators in National League for Nursing accredited baccalaureate programs in the state of California who describe themselves as being involved in faculty practice. We have defined faculty practice as:

> The involvement of a faculty member in the provision of direct nursing care to patients. This practice might be facilitated through joint appointment, dual appointment, a school-run service, summer clinical employment, or moonlighting.

The questionnaire will take approximately 15 minutes to complete and it can be returned in the self-addressed, stamped envelope which is provided for your convenience. To facilitate data analysis, please return the questionnaire by February 15, 1989. The only identification on the questionnaire is a code number which will assist us in data analysis. Please be assured that your anonymity will be maintained. If you have any questions regarding the survey, please feel free to contact Samar K. Hage or Patricia J. Nervino at (408) 646-4258, Monday through Friday from 8 a.m. to 5 p.m.

We hope that the results of our research will further increase nursing's understanding of faculty practice. A final copy of this research will be available in the library at San Jose State University upon completion of our thesis. If you are interested in the results of the questionnaire, please feel free to contact us and we will share the results with you once they are analyzed.

Your contribution to this area of study is very important, therefore, your timely response is greatly appreciated. Thank you for your consideration.

Sincerely,

Samar K. Hage, RN, BSN

Patricia J. Nervino, MS, RN

APPENDIX C

Questionnaire

Thank you for your time and cooperation with this important study. If you have any additional remarks regarding this survey, please feel free to comment in the space provided.